Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES

The Prior Authorization Dental Request Form (PA/DRF) is to be used by all dentists requesting prior authorization (PA) for dental or orthodontic services.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Photocopy the necessary pages of the PA/DA form from Appendix 22 of this handbook.

Submit the PA/DRF and the appropriate page(s) of the PA/DA to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DRF COMPLETION INSTRUCTIONS

BOX #	DESCRIPTION	INSTRUCTIONS
1	PROCESSING TYPE	Mark the appropriate box.
2	RECIPIENT'S MEDICAID ID NUMBER	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
3	RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	Enter the recipient's name exactly as it appears on the Medicaid identification card.
4	RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	Enter the address of the recipient's place of residence. The street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, enter the name of the nursing home or facility.
5	RECIPIENT'S DATE OF BIRTH	Enter the recipient's date of birth in MM/DD/YY format.
6	RECIPIENT'S SEX	Specify male or female.
7	BILLING PROVIDER NUMBER	Enter the billing provider's 8-digit Medicaid provider number. Use the billing number you will use on Medicaid claims.
8	PERFORMING PROVIDER NUMBER (if different)	**The performing provider is the dentist who will actually provide the service. Complete this section if the performing provider is different from the billing provider.** Enter the performing provider's 8-digit Medicaid provider number.
9	BILLING PROVIDER'S ADDRESS (if stamped, please stamp every copy.)	Enter the name and the address of the billing provider. The street, city, state, and zip code must be included. If you use a stamp for the name and address, please stamp all three copies of the PA/DRF form. No other information should be included in this section because it also serves as a return mailing label.

Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES
(continued)

BOX #	DESCRIPTION	INSTRUCTIONS
10	PROVIDER TELEPHONE NUMBER	Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the provider.
11	INDICATE IF THE SERVICE WILL BE PERFORMED IN:	Mark the proper place of service code which desginates where the requested service/procedure will be provided. Do not mark any of these boxes if the requested service will be performed in a location other than inpatient hospital, outpatient hospital, ambulatory surgery center, or dental office.
12	TOOTH NUMBER (*or letter*)	Using the numbers and letters on the Tooth Chart in box 17, identify the tooth number or letter for the service requested.
13	PROCEDURE CODE	Enter the appropriate procedure code for each service/procedure requested on each line.
14	QUANTITY (*of service requested*)	Dentists: Enter the number of services requested for each service/procedure requested. If requesting five years of prophylaxes or fluoride services for permanently disabled recipients, with four services requested each year, request 20 units of service. Orthodontists: Enter a quantity of "1" in this box.
15	DESCRIPTION (*of service*)	Enter a written description corresponding to the appropriate procedure code for each service/procedure.
16	FEE	Enter your usual and customary charge for each service/procedure requested (the amount charged to non-Medicaid patients).
17	PERIODONTAL CASE TYPE, TOOTH CHART, & X-RAYS	For Partials, Endodontics, and Periodontics, circle the periodontal case type. On the diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. Indicate the number and type of x-rays submitted with this prior authorization request. (We request this information to ensure we receive all the x-rays sent with the PA/DRF.)
18	TOTAL FEES	Enter the anticipated total charge for this request.
19	RECIPIENT/GUARDIAN SIGNATURE (*Optional*)	The recipient or the recipient's guardian can sign and date the prior authorization request so they are informed about the request.
20	PROVIDER SIGNATURE (*If stamped, please stamp every copy.*)	The provider must sign and date the prior authorization request. If you use a stamp for the provider signature, please stamp all three copies of the PA/DRF form.

DETACH AND KEEP THE BOTTOM COPY OF THE PA/DRF.
LEAVE THE TOP TWO FORMS ATTACHED.

Keep the bottom copy of the PA/DRF. You can discard this copy once you receive the processed prior authorization request.

PROVIDER CHECKLIST: The bottom copy features a Provider Checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult Appendix 24 of this handbook.